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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **EDGARDO CANO LIBAN** **1281 Old Janal Ranch Road** **Chula Vista, CA 91915** **Registered Nurse License No. 567217** Respondent.	Case No. 2011- 984 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 1, 2000, the Board of Registered Nursing issued Registered Nurse License Number 567217 to Edgardo Cano Liban (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2012, unless renewed.

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JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY PROVISIONS

6. Section 2761 of the Code states:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct, which includes, but is not limited to, the following:
>
> (1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions....

REGULATORY PROVISIONS

7. California Code of Regulations, title 16, section 1443, states:

> As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5.

8. California Code of Regulations, title 16, section 1443.5 states:

> A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:
>
> (1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided.

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

FACTS

10. On April 11, 2008, Respondent was employed as a clinical nurse at the Behavioral Health Unit of Sharp Grossmont Hospital (a division of Sharp Health Care). He began his employment there on January 22, 2007 until his voluntary resignation following the subject incident. Respondent worked as a Staff RN in the Emergency Department at another division of Sharp Health Care prior to his employment at Sharp Grossmont Hospital.

11. After Respondent's change of employment to Grossmont Hospital, Respondent received orientation to all codes, including code blue, and the location of the crash cart and emergency equipment. In January 2008, Respondent successfully completed Professional Assault Crisis Training, or Pro-ACT, which is required prior to placing a patient in restraints or assisting in this task. At the time of the subject incident, Respondent had a current Advanced Cardiovascular Life Support (ACLS) card that expired in January, 2009.

12. On April 2, 2008, after four months of inpatient treatment at Sharp Mesa Vista, in San Diego County, patient Jeffrey C., a 25-year-old, obese male with a history of schizophrenia and a pre-existing heart condition, was transferred to Crest Loma Mental Health Rehabilitation Center (Crest Loma). Within a few hours of his arrival at Crest Loma, the staff became concerned about Jeffrey C.'s mental status, including his delusional behavior. He injured his knees and feet after forcefully dropping to his knees to pray. Unable to ensure his safety at Crest Loma, he was transported to Sharp Grossmont Hospital Emergency Room for evaluation on April 3, 2008, and was subsequently admitted to the locked Behavioral Health Unit under the supervision of Dr. BPM.

13. On the second day of his hospitalization, April 4, 2008, Dr. BPM noted that Jeffrey C. had an episode in which he was throwing himself to his knees and banging his head on the floor. Jeffrey C. was administered Thorazine and placed in seclusion and 5-point restraints for his safety. On April 8, 2008, Jeffrey C. had another episode of throwing himself to his knees, banging his face on the floor, and at about 1500 hours, he was placed in seclusion and five-point restraints in a prone position. At 1515 hours, Jeffrey C. was observed to be straining against the restraints and pressing his face into the mattress. At 1530 hours, Jeffrey C. demanded to be turned over onto his back and continued to strain against the restraints. At 1615 hours, hospital staff assisted Jeffrey C. onto his back.

14. On or about April 11, 2008, Jeffrey C. had a visit from his mother and was behaving appropriately. He abruptly dropped to his knees and began praying. Jeffrey C. continued to get up and drop to his knees. Hospital staff tried to hold him up to soften his fall. After continuing this behavior, Jeffrey C. was escorted to the seclusion room by Respondent, Nurse D.P. and another male staff member. Jeffrey C. struggled, was uncooperative in that he strained and twisted his body and wrists and spit at staff. At approximately 1945 hours, Respondent and Nurse D.P. placed Jeffrey C. in seclusion with five-point restraints in a prone (face down) position on a mattress. During the time Jeffrey C. was in restraints, he raised his body off the mattress, thrust his face and body into the mattress, causing the mattress to shift. Dr. BPM noted that staff indicated Jeffrey C. was holding his breath and counting his fingers, and also spitting on

the wall. Dr. BPM ordered that the patient be observed on a one-to-one basis and prescribed Thorazine. An LVN, C.K., was posted outside Jeffrey C.'s seclusion room.

15. At approximately 2030 hours, Nurse D.P. took over Jeffrey C.'s watch. Upon entering the room, Jeffrey C.'s face was face down in the mattress. Nurse D.P. noted that Jeffrey C. was blue, nonresponsive and not breathing. Nurse D.P. called Code Blue and Respondent arrived. Respondent, Nurse D.P. and other staff turned Jeffrey C. over and removed his restraints. One of the other staff members left the room to retrieve the crash cart. Respondent immediately started compressions and instructed Nurse D.P. to begin rescue breathing but Nurse D.P. did not give any breaths until the crash cart arrived about 40 seconds later with an Ambu bag (bag valve mask). Jeffrey C. was pronounced dead at 2046 hours.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Restraints)

16. Respondent is subject to disciplinary action under Code section 2761(a) in that Respondent engaged in unprofessional conduct when Respondent failed to take into account the risk factors contraindicating prone restraints when he and Nurse D.P. placed Jeffrey C. in seclusion with five-point restraints in a prone (face down) position, as more fully set forth in paragraphs 10-15 above, and incorporated by this reference as though set forth in full herein. Those risk factors include obesity, pre-existing heart disorders, the prior administration of medication as a chemical restraint (Thorazine) and the exhibition of signs of agitated delirium.

SECOND CAUSE FOR DISCIPLINE

(Incompetence - Restraints)

17. Respondent is subject to disciplinary action under Code section 2761(a)(1), in conjunction with sections 1443 and 1443.5 of title 16, California Code of Regulations, in that Respondent demonstrated incompetence by failing to formulate or evaluate an appropriate plan of care by restraining, and leaving, Jeffrey C. in a five point restraint in a prone or face down position when Jeffrey C.'s risk factors of obesity, excited delirium syndrome and a pre-existing heart disorder would have cautioned against restraint in a prone position, as more fully set forth in paragraphs 10-15 above, and incorporated by this reference as though set forth in full herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence - CPR)

18. Respondent is subject to disciplinary action under Code section 2761(a)(1), in conjunction with sections 1443 and 1443.5 of title 16, California Code of Regulations, in that Respondent failed to follow the ABC principles of CPR, which requires establishing an airway ("A" – airway), giving 2 breaths ("B" – breathing) before starting compressions ("C" – circulation) to provide artificial circulation. Instead, Respondent immediately began compressions before establishing an airway and giving 2 breaths, as more fully set forth in paragraphs 10-15 above, and incorporated by this reference as though set forth in full herein.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 567217, issued to Edgardo Cano Liban;

2. Ordering Edgardo Cano Liban to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 6/14/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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